Public Health
Seattle & King County

3-DAY CRITICAL MEDICATION AUTHORIZATION FORM

(These medications are to be used only in case of disaster requiring the child to remain at care past the usual hours)

Child's Name:	**Date of Birth/Age:**
Name of Medication:	**Reason for Medication:**
Date:	**Date to be replaced/rotated*:** **Expiration date of medication:**
☐ **Scheduled Times to be given:**	**Amount to be given:**
☐ **Medication is to be given as needed for the following symptoms:**	
Possible Side Effects:	☐ **Oral** ☐ **Topical** ☐ **Other**
☐ **Above information consistent with label?**	**Requires Refrigeration:** ☐ **yes** ☐ **no**
Special Instructions:	

* Maximum 6 months – sooner as needed.

_____ _____

Parent/Guardian Signature** **Date**

_____

Daytime Phone Number

_____ _____

Physician Signature (required) **Date**

_____

Physician Phone Number

****Please be sure to inform program if child's health status/medication changes!**